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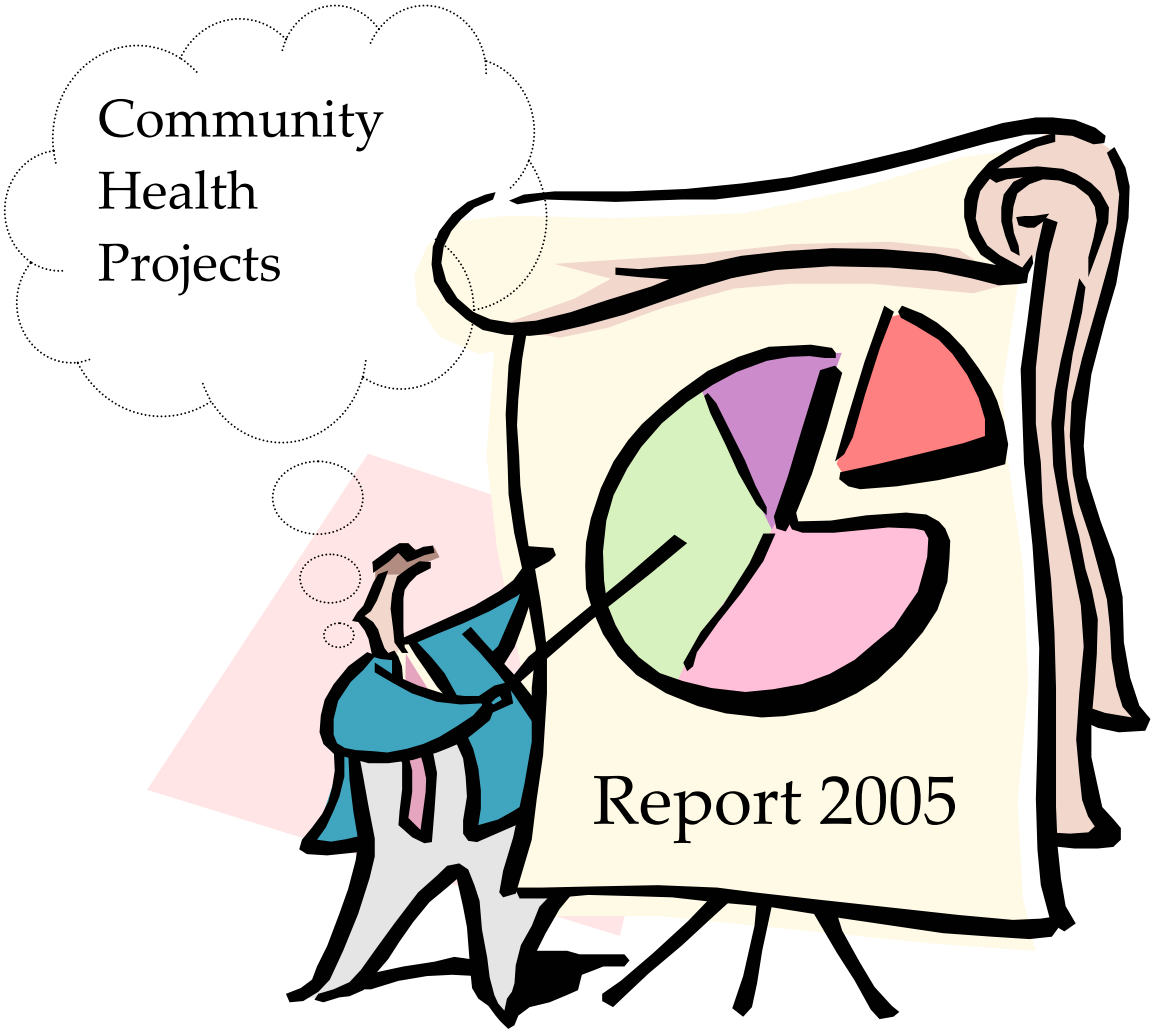
Faculty of Dentistry

Dental Public Health

Oral Health Care Services for Residents of Children and Adolescents Homes



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Oral Health Care Services for Residents of Children and Adolescents Homes

May 2005

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1. ABSTRACT

In Hong Kong, there are a number of children and adolescents who, due to various reasons, are living out of their homes in temporary residential facilities provided by various social welfare agencies. These children and adolescents may have difficulties in accessing proper dental care, and their oral health should not be neglected. The aim of this community oral health project was to provide basic dental care services to the residents in selected children and adolescents homes in Hong Kong.

The participants of this project were the children and adolescents living in two of the four residential homes run by the Salvation Army. After obtaining appropriate consent, an interview with and a clinical examination of the participants were carried out in the children and adolescents homes. After the examination, appropriate preventive and restorative dental treatments were provided to the residents according to their needs using portable dental equipment.

A total of 31 residents in the two selected homes, 21 male and 10 female, aged between 7 to 20 years, participated in this project. It was found that most of them did not have a high level of dental caries nor poor oral hygiene. However, a number of the residents had some untreated caries lesions and many adolescents had dental calculus. Utilization of dental service was high among the residents who were primary school students because most of them joined the government School Dental Care Service. However, the older residents had little access to proper dental care. In this project, topical fluoride varnish was applied onto the teeth of 17 participants, scaling was performed on 9 adolescents, and 27 fissure sealants and 8 restorations were placed.

It is concluded that most of the needed dental care of the residents in the two selected homes was satisfactorily delivered in this project and this was highly appreciated by the service recipients. It is recommended that special dental care services, financially supported by the government, be arranged for the residents of children and adolescents homes in Hong Kong due to their special circumstances. The service providers can be dentists working in the government or in non-governmental organizations. Outreach dental service using portable equipment is an appropriate mode of service delivery to this special need group and should be promoted.

2. INTRODUCTION

Dental care services for children and adolescents in Hong Kong are mainly provided by the following services:

(1) The government School Dental Care Services,
(2) The government general dental services,
(3) Dental services provided in the private sector,
(4) Dental services provided in the Prince Philip Dental Hospital, and
(5) Dental services provided by non-profiting-making organizations.

Primary school children in Hong Kong are eligible to join the government School Dental Care Services (SDCS) and the annual enrolment fee is only $20. The dental services included annual examination, oral health education, prevention, scaling, restorations, and other necessary simple dental treatments. The dental care is provided mainly by dental therapists under the direct supervision of government dentists in large clinics located in various districts throughout the territory. The benefits of the SDCS are well supported by the low caries level and the satisfactory oral hygiene habits of the 12-year-old children found in the 2001 Oral Health Survey conducted by the government.[1] The mean DMFT score of the surveyed children was only 0.8 and 68.3% of them reported brushing their teeth twice or more daily.

Besides the SDCS, the government also provides comprehensive dental care services to the dependent children of civil servants. Some government dental out-patient clinics provide emergency dental treatments like extractions to the public, including children and adolescents.

The dental service provided by private dentists is open to all people as long as they are able to meet the charges. There are a few peadiatric dental specialists in the private sector in Hong Kong. At present, private dental insurance is not common in Hong Kong and there are no guidelines on how the private dentists should charge their patients. Thus, there are people who may have difficulty in accessing dental services in the private sector due to financial hardship.

Dental services provided in the Prince Philip Dental Hospital (PPDH) is heavily subsidized by the government and patients only need to pay a nominal fee for their treatment if they are admitted as patients for teaching or research purposes. However, because of its nature as a teaching hospital only, the number of patients seen per day is relatively small.

A number of non-profit-making organizations in Hong Kong, mainly the ones that provide social welfare services, also provide dental care services at a fee lower than the prevailing private market rate to the general public.

Children and adolescents living with their parents can obtain their needed dental care through the aforementioned channels. However, there are children in Hong Kong who have mishaps and are living in various institutions for different reasons. Theses cases are usually first assessed by social workers in the government Social Welfare Department and then, if appropriate, sent to the residential institutions through the central referral system.[2] Non-governmental organizations that provide residential care service to children and adolescents in Hong Kong include Po Leung Ku, the Tung Wah Group of Hospitals, and the Salvation Army. Because of various family problems, these children and adolescents are living out of their homes until their family problems are settled. The organizations provide temporary residential care for people aged from 3 to 21 years. The main objectives of setting up these residential homes are to offer basic and family style care; to provide training in independent living skills; to provide guidance on social, emotional, physical and personal development, and family relationship improvement. Due to financial constraints, the organizations can only provide for the basic needs of the children which do not include professional dental care services.

The residents in these institutions who are primary school children can join the SDCS and receive regular basic dental care services. However, not all of the school children in these institutions have joined the SDCS due to various reasons. Moreover, the older residents who are not studying in primary school are not eligible to join the SDCS. Sometimes, non-profit-making organizations, e.g. Project Concern Hong Kong, will provide free or subsidized dental care services to the residents of welfare institutions. However, many residents in children and adolescents homes are not so fortunate and are

not receiving regular dental care services. The disadvantaged children and adolescents in these institutions should not be neglected. Special dental care should be organized for them because good oral health is an essential part of their well-being.

In order to know more about the situation of the children and adolescents living in welfare institutions, and to provide the necessary basic dental care to these people, our group of fourth year dental students decided to conduct a community oral health project on this population group.

3. AIM AND OBJECTIVES

The aim of this community oral health project was to provide simple basic dental care services to the residents in selected children and adolescents homes in Hong Kong.

The objectives of this community health project were:

1. to find out the oral health-related behaviours, oral health status and dental treatment need of the residents in the selected homes;
2. to provide an oral health education talk and to give individualized oral hygiene instructions to the residents; and
3. to deliver appropriate preventive and restorative dental treatments to the residents according to their treatment needs.

4. MATERIALS AND METHODS

4.1. Selection of residential homes and children

During the preparation for this community health project, we had read up a number of brochures about social welfare services in Hong Kong and browsed through the websites of some non-governmental organizations that offer residential care services to children and adolescents.[3-6] With further enquiry through telephone calls, we found out that some of the residential homes for children and adolecents did not have dental services organized for their residents, apart from enroling some eligible children who were studying in primary school in the SDCS.

The Salvation Army is one of the non-governmental organizations in Hong Kong that provides residential care services to children and adolescents. It has set up four residential homes in different districts around Hong Kong. These are:

1) Yue Wan Boys' Hostel offering 15 residential places,
2) Tai Wu Hau Small Group Homes offering 24 residential places,
3) Ping Tin Small Group Homes offering 24 residential places, and
4) Wan Tsui Home for Boys offering 46 residential places.

The four hostels of the Salvation Army do not differ greatly from one another. During the planning our project, we contacted the social workers of all the hostels and had a preliminary discussion with each of them on the feasibility of conducting our project. Information about our project was sent to the social workers who were interested in working with us (Appendix 1). After further discussion with the supervisors of these homes, the Ping Tin Small Group Homes and the Yue Wan Boys' Hostel were selected to be our collaborators. The target population of our project was all the residents living in these two homes.

There were 22 residents, with age ranging from 6 to 18 years, in the Ping Tin Small Group Homes and 9 adolescents, aged 15 to 19 years, living in the Yue Wan Boys' Hostel. All of these children and adolescents were healthy with no relevant medical history that warranted special precautions.

4.2. Project preparation

Before the implementation of our community oral health project, we made a site visit to each of the two selected homes. During the visit, a meeting between our student group members, our teacher advisors and the supervisor of the home was held. In this meeting, the nature of the project was explained to the supervisor and the roles of the different parties involved were clarified. The room space that could be used for carrying out the project was identified as well as fixing the dates on which the dental examinations and treatments would be carried out.

After the meeting, information about the oral health project was given to the guardians of the children, when appropriate, and consent for their child's participation in this project was obtained before the implementation of our project.

A special form for recording the findings of the clinical examination (Appendix 2) was designed by our group members. Another form for recording the treatment performed and individualized advice on oral health practices (Appendix 3) was also prepared.

A list of necessary portable equipment, hand instruments and treatment consumables needed for carrying out the dental examinations and treatments was prepared (Appendix 4) and the materials were collected.

Oral health education pamphlets appropriate for use in our project were collected from the government Oral Health Education Unit (OHEU). These were for distribution to the residents and staff of the children and adolescent homes during the oral health education programme. Oral hygiene demonstration aids were borrowed from the Prince Philip Dental Hospital (PPDH).

Training on how to place atraumatic restorative treatment (ART) restorations and fissure sealants was provided by one of our teacher advisors, Prof. Edward Lo, in the PPDH prior to carrying out our project.

4.3. Project implementation

Our project in the homes comprised of three elements, namely clinical examination, dental treatment and oral health education.

4.3.1. Clinical examination

Clinical examinations of the project participants were carried out in the Ping Tin Small Group Homes on February 26, 2005 from 9:00 am to 5:00 pm, and in the Yue Wan Boys' Hostel on March 4, 2005 from 5:30 pm to 10:00 pm.

In the clinical examinations, three members of our student group acted as the examiners and another three members acted as chairside assistants. All group members took turn so that every member had the experience of being an examiner and that of being a chairside assistant. A mouth mirror and a straight probe were used by the examiner for each examination. Disposable gloves and gowns were worn by the examiners and assistants. A portable autoclave was used for proper sterilization of all instruments. The clinical examinations and dental treatments were carried out under universal infection control.

The treatment options available included oral hygiene instructions, scaling, topical fluoride application, fissure sealant, restoration, extraction and referral. Questions concerning the oral hygiene practices of the participant was asked during the examination. The decision as to whether a participant needed special oral hygiene instructions and dietary advice was based on the information obtained from asking the participant and the clinical examination. Clinical diagnostic criteria used in the PPDH, other than the use of radiograph, were adopted in the examinations to record the findings. A global assessment of the oral hygiene status of each project participants was made by the examiner. Fissure sealant was indicated for teeth with deep or sticky pits and fissures. Need for a filling were recorded when there was a carious cavity or substantial missing tooth structure in the anterior teeth, e.g. a fractured incisor. After the clinical examination, an individualized treatment plan was formulated and recorded down in the special form.

4.3.2. Dental treatments

The indicated dental treatments were carried out right after the clinical examination by the same operators. The following types of treatments were provided in our project:

1. Prevention- oral hygiene instruction, fluoride varnish applications,and fissure sealants
2. Periodontal treatment- scaling
3. Restorations- composite fillings and ART glass ionomer fillings

A varnish containing 2.26% sodium fluoride (Duraphat, Inpharma) was applied onto teeth that were judged to be at risk for caries and on initial caries lesions. Scaling was performed by using hand instruments as well as ultrasonic scalers with adequate water cooling. Fissure sealants were placed on teeth with deep or sticky pits and fissures using the ART technique.[7] The ART technique was used when restoring small carious lesions in the posterior teeth. This technique involved the removal of the carious tooth substances by hand excavation and restoration of the prepared cavity with a hand-mixed high-strength glass-ionomer material (Ketac-Molar Easymix, 3MEPSE). Composite resin (Spectrum, Dentsply) was used to restore the carious lesions in the anterior teeth for better aesthetics. Local anaesthesia injection was given prior to cavity preparation when pain or discomfort was anticipated. The treatment performed was recorded on a specially designed patient record form after completion of the treatment.

4.3.3. Oral health education

Oral hygiene instructions were given to the project participant on the day of dental treatment using oral hygiene demonstration aids. Special emphasis was paid on the prevention of common dental diseases. The content included how to select an appropriate toothbrush, use of fluoridated toothpaste, proper toothbrushing technique, proper diet and the importance of regular dental care. Questions raised by the participants were answered.

Oral health education leaflets from the OHEU were distributed to the participants during the talk. Individualized form recording the dental treatment performed and the advice on oral health practices was given to the project participants. A set of toothpaste and toothbrush was given to each participant as a souvenir.

An additional oral health talk was given to the residents in the Ping Tin Small Group Homes on March 1, 2005. Small group discussions were also held so as to reinforce the oral hygiene instructions and the oral health messages

4.3.4. Reporting

After the conduction of the community oral health project, a summary report on the activities and the services provided to each participant was sent via fax to each of the two homes.

5. RESULTS

There were altogether 31 participants in our community oral health project, 22 of them were from Ping Tin Small Group Homes and 9 were from the Yue Wan Boys' Hostel.

5.1. Demographic background

There were 21 boys and 10 girls among our project participants and their age ranged from 7-20 years (Table 1). Eleven children were below 12 years of age and were studying in primary school. Most of these children were receiving dental care services from the government School Dental Care Service.

Table 1. Number of participants according to age and gender.

Age (years)	No. of boys	No. of girls	Total
Below 12	8	3	11
12 or above	13	7	20
All ages	21	10	31

5.2. Perceived problems

Of the 31 participants, 21 (68%) of them reported that they had no perceived dental problems. Among the participants below 12 years old, toothache and tooth mobility were reported by two children while a complaint of calculus and visible caries was reported by one child.

Among the older participants, aged 12 years or above, complaint of calculus, discomfort from wisdom teeth, and bleeding gum, were reported by one adolescent each. Two adolescents said that they thought they had decayed teeth.

5.3. Oral hygiene habit

Regarding the toothbushing habit of the participants, all of them brushed their teeth at least once a day (Table 2). All of the participants under the age of 12 years and 90% of the older participants reported that they brushed their teeth twice daily, in the morning and also at night.

Table 2. Number of participants according to their age and toothbrushing habit.

Frequency of toothbrushing	Below 12 years	12 years or above	Total
Once a day	0	2	2
Twice a day	11	17	28
Three times a day	0	1	1

5.4. Dental care experience

Twenty-nine (94%) participants had previously received some dental care services. All of the eleven children aged below 12 years had received dental care services. Ten of them had participated in the School Dental Care Service and the remaining child had received dental treatment from a private dentist (Table 3).

Among the participants aged 12 years or above, seven of them had been under the care of the School Dental Care Service, seven had received treatment from private dentists, two had visited the Prince Philip Dental Hospital for dental care, while one adolescent did not specify the source of his dental care. Only two adolescents had not received any dental care service before.

Table 3. Number of participants according to their age and dental care experience.

Source of dental care	Below 12 years	12 years or above	Total
School Dental Care Service	10	7	17
Private dentist	1	7	8
Prince Philip Dental Hospital	0	2	2
Not specified	0	1	1
Had not received care before	0	2	2

5.5. Oral hygiene status

In the clinical examinations, it was found that 20 of the participants had a satisfactory level of oral hygiene and the status in another eight was acceptable (Table 4). Only three participants had unsatisfactory oral hygiene, one was below and two were above the age of 12 years.

None of the eleven participants aged below 12 years had calculus (Table 5). As for the older participants, calculus was detected in most of them (55%).

Table 4. Number of participants according to their age and oral hygiene level.

Level of oral hygiene	Below 12 years	12 years or above	Total
Satisfactory	10	10	20
Acceptable	0	8	8
Unsatisfactory	1	2	3

Table 5. Number of participants according to their age and amount of calculus.

Amount of calculus	Below 12 years	12 years or above	Total
No	11	9	20
Slight	0	10	10
Moderate	0	1	1

5.6. Oral health status

The gingival health condition of the participants was generally good. Around 40% of the participants in both age groups did not have obvious signs of gingival inflammation while most of the other participants had slight inflammation only (Table 6). Only two of the older participants showed moderate level of gingival inflammation and no participant had severe inflammation.

Table 6. Number of participants according to their age and level of gingival inflammation.

Level of gingival inflammation	Below 12 years	12 years or above	Total
No	4	8	12
Slight	7	10	17
Moderate	0	2	2
Severe	0	0	0

The mean DMFT scores for the younger and the older participants were 0.45 and 2.5 respectively(Table 7). Decayed teeth (DT) and filled teeth (FT) accounted for around half of the DMFT scores, while missing permanent teeth due to caries were uncommon.

Table 7. Mean number of decayed teeth (DT), missing teeth (MT), filled teeth (FT), and DMFT of the participants according to their age.

	Below 12 years	12 years or above
Mean DT	0.18	1.10
Mean MT	0.00	0.15
Mean FT	0.27	1.25
Mean DMFT	0.45	2.50

5.7. Dental service provided

In this project, topical fluoride varnish was applied onto the teeth of 17 participants while scaling was provided to nine adolescents (Table 8). Eleven participants had received fissure sealants and a total of 27 teeth were sealed. We had placed a total of 12 restorations, seven ART restorations in four participants and five composite restorations in another four participants. One participant had signs of secondary caries around a large old amalgam restoration and he was referred to the PPDH for further care.

Table 8. Number of participants according to their age and the dental care received.

Type of dental care	Below 12 years	12 years or above	Total
Oral hygiene instruction	13	8	21
Fluoride varnish	9	8	17
Scaling	0	9	9
Fissure sealant	4 (9)*	7 (18)	11 (27)
ART restoration	1 (2)	3 (5)	4 (7)
Composite restoration	1 (1)	3 (4)	4 (5)

* numbers in parathesis are the numbers of teeth treated

6. DISCUSSIONS

Originally, the main objective of our group's community oral health project was to deliver appropriate oral health care services to the residents in children and adolescents' homes who were not under covered by the government School Dental Care Service (SDCS). It was not difficult for us to identify and contact our target population group. When searching on the internet, we quickly identified the children and adolescents served by the Salvation Army's residental care service as our potential project participants. The residents in the Yue Wan Boys' Hostel were all adolescents and were not eligible to join the SDCS. In our meeting with the social worker of the Ping Tin children's home, she requested us to extend our service to the children who were studying in primary school and were covered by the SDCS. This was because she believed that the oral health condition of all the residents was poor and that the amount of dental care services provided by the SDCS might not be sufficient. We accepted her request, and in this project, dental care service was provided to all the residents in the two homes that we visited. This had maximized the utilization of our services and brought improvements in oral health to all residents.

Before implementing our project, we anticipated that the oral hygiene and oral health condition of the children and adolescents under residential care was rather poor. However, in the interviews and the clinical examinations, we found that the oral hygiene condition of most residents were satisfactory. Most of them had no or only little calculus. Besides, the oral hygiene habit of the residents was generally good. All of them brushed their teeth at least once a day, usually at night, and most brushed two times or more. Furthermore, the need for dental caries related treatment was not high in most of our project participants. In fact, most of them just needed a few preventive treatment items like fissure sealants and fluoride varnish application. Only a few participants needed ART restorations or composite restorations. The good oral hygiene habits and conditions in most of the children may be related to their partcipation in the SDCS, and the receipt of proper dental health care and oral health education during their childhood.

Despite the generally good oral health condition in the majority of the residents in the two homes, untreated caries lesions were found in a number of the children and adolescents. These participants had a rather high need for preventive dental care and dental restorations. In fact, the mean DMFT score of our project participants aged 12 years or above was 2.5 which is much higher than the mean DMFT score of 0.8 among the 12-year-old children in Hong Kong.[1]

We had provided various types of dental treatment to a total of 31 residents in the two homes. We found that the portable equipment and time available for this project were adequate for us to carry out the clinical examinations and necessary treatments, but there were two exceptions. In the first case, an adolescent required extraction of an impacted lower third molar. Lack of surgical equipment and radiographs made this treatment not feasible to be carried out in the adolescents home. Therefore, the participant with this condition was advised to visit a dentist for proper treatment as soon as possible. In the second case, there was a shadow along the margin of an old amalgam filling. A firm diagnosis of recurrent caries could not be made without taking a bitewing radiograph and the filling could not be removed by using hand instruments alone. The participant was referred to the PPDH for further investigation.

No major problems were encountered during provision of preventive and restorative treatments in this project. As good moisture control would be difficult to achieve under the field condition, resin-based fissure sealant was not used in this project. Since placement of Atraumatic Restorative Treatment (ART) sealants under field condition had been shown to give very good results,[8,9] this treatment was chosen. The ART approach was also used in this project to restore the carious cavities in the posterior teeth. We found the ART technique simple to learn and to apply. It allows a large number of restorations to be placed in a relatively short time and requires a few hand instruments only. Good clinical results of these restorations have been reported.[9]

In this project, resin composites were used to restore carious lesions in anterior teeth due to their superior esthetic result. These restorations were placed under rubber dam because good moisture control is essential for their clinical success. In the process, we found out that the restorations could be placed with the aid of hand instruments and

cellulose matrix band, and the use of a handpiece and dental burs was not essential.

In this project, we have adopted an outreach service mode in delivering the necessary dental care to the children and adolescents in the two homes. We brought simple portable equipment, instruments and consumables materials to where our target population lived and treat them there, i.e. in their homes, rather than bringing them to the dental hospital for treatment. In this way, it was not necessary for the children and adolescents to travel a long distance to the dental hospital. The service receipients and the social workers found this service very convenient to them. The physical access barrier to dental care was thus removed. We were informed that this mode of outreach dental care service delivery was welcome by the recipients and they would like to receive this service on a regular basis in the future.

Through conducting this community oral health project, all members of our student group have gained a lot from the contact with disadvantaged children and adolescents, had a better understanding of the social setting and the dental health care system in Hong Kong. We have also acquired new clinical skills and a valuable experience in carrying out community dental service. It is our group's general consensus that conducting this project is a very fulfilling experience for us.

7. CONCLUSIONS

After conducting this project, the following conclusions were drawn:

1. Most of the residents in the two children and adolescent homes in this study did not have a high level of dental caries nor poor oral hygiene. However, a number of the residents had some untreated caries lesions and many adolescents had dental calculus. Thus, there is still a need for prevention and special mode of dental service for this special group of children and adolescents in Hong Kong.

2. Utilization of dental service was high among the residents who were primary school students, because most of them had joined the SDCS. However, the older residents had little access to proper dental care.

3. Provision of oral health education, topical fluoride varnish, fissure sealants, scaling, and restorations was accomplished satisfactorily using portable equipment in this project. This outreach dental service was welcomed by the service recipients.

8. RECOMMENDATIONS

Special dental care services should be arranged for the residents of children and adolescents homes in Hong Kong due to their special circumstances. The service should be financially supported by the government because this special group is under the care of social welfare services. The service providers can be dentists working in the government or in non-governmental organizations. Outreach dental service using portable equipment is an appropriate mode of service delivery to this special need group and should be promoted.

9. ACKNOWLEDGEMENTS

We would like to express our sincere gratitude to the social workers in the two participant homes for their indispensible assistance in this project, in particular:

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- Ms. Becky W. Y. Sun of the Ping Tin Small Group Homes

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- Prof. Edward C. M. Lo
- Dr. Anthony H. H. Wong

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Appendix 1

Oral health care for the residents in the children and adolescents hostels of the Salvation Army

Project organizers : Year 4 dental students (Group 6)

Teacher supervisor : Prof. Edward C.M. Lo

Aim: To deliver free oral health care for the residents in the children and adolescents hostels of Salvation Army, which includes dental treatment and oral health education.

2. Objectives:
- To deliver dental treatment according to their treatment needs
- To implement an oral health program to improve their oral health

3. Proposed project period: 27/2- 6/3/2005 (around 2 days per hostel)
Time: to be confirmed

4. Materials and Methods

The program consists of 3 parts:
1. Oral health education including dietary advice
2. Oral health assessment through clinical examination
3. Delivery of dental treatment

Oral health education
- This is given in the form of small group discussion with teaching aids and pamphlets
- Tailor-made individual advice on oral health practice

Delivery of dental treatment
The following types of treatment will be provided:
- Oral hygiene instruction 口腔衛生指導
- Scaling & prophylaxis 洗牙
- Fluoride varnish application 氟素
- Fissure sealant 牙紋防蛀劑
- Restorations 補牙
- Referral if required 轉介

Contact persons: Jim, KP Hung (96053120)
Anne, WY Chung (97726630)

Appendix 2

Patient's Name _____ (Chinese) _____ (English)

Sex: _____ **Age:** _____

Perceived Problems: _____

_____

_____

Brushing Habits:

1) Not everyday 2) Morning 3) Night 4) Both morning and night

5) Others (please specify) _____

Have you received any dental treatments before?

Yes ☐: (please specify) _____

_____

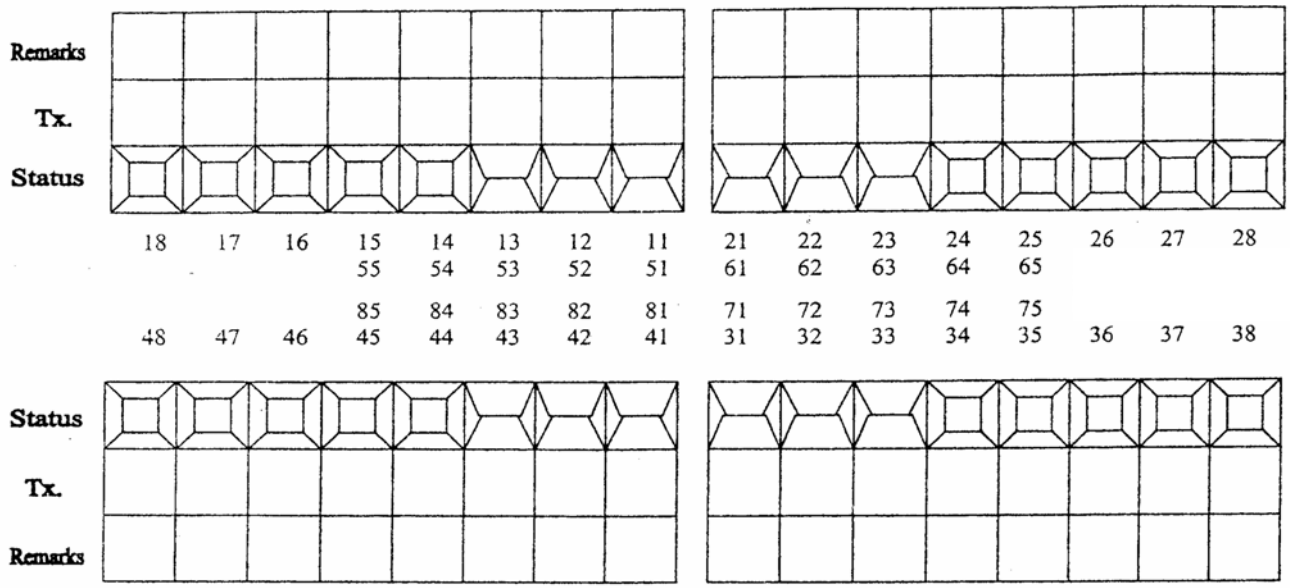
No ☐

Special medical conditions:

Yes ☐: (please specify) _____

_____

No ☐



Oral hygiene: ☐ Satisfactory ☐ Acceptable ☐ Dissatisfactory

Calculus: ☐ No ☐ Slight ☐ Heavy

Gingival inflammation: ☐ No ☐ Slight ☐ Moderate ☐ Severe

Appendix 3

Treatment Planing

- ☐ OHI _____
- ☐ Scaling _____
- ☐ Fluoride _____
- ☐ Fissure Sealant _____
- ☐ Restoration _____
- ☐ Extraction _____
- ☐ Others _____

Completed by _____ Date: _____

Day Sheet

Date	Treatment	Operator

Appendix 4

Equipment checklist

1. Disinfection	
Name	Quantity
Lubisept	2 bottles

2. Examination kit	
Name	Quantity
Straight probe	20
Periodontal probe	20
Mouth mirror	20

3. Scaling kit	
Name	Quantity
EMS machine	1
Tip	10
Sickle scaler	4

4. Rubber dam kit	
Name	Quantity
Rubber dam kit	1
Rubber dam	10

5. Forceps	
Name	Quantity
Lower universal	1
Upper premolar	1
LLS	1
LLM	1
LLL	1
Artery forcep	2

6. Others	
Name	Quantity
Non-perforated box	4
Perforated metal box	8
Subgingival metal matrix	1 bag
Supragingival metal matrix	1 bag
Cellulose matrix	1 bag
Dycal	1 set
Esthetic-x composite	1 set
Fluoride varnish	1 tube
Curing light (tip & shield)	1
Wooden wedge	1 box
Syringe	4
Long LA needle	10
Short LA needle	10
Xylocaine	20
Topical xylocaine	1 tube
Paracetamol	8 tabs x 28 bags
Metal spatula	1
Disposable gown	20
Cotton roll	4 packs
Cotton bud	1 bag
Mixing pad	1
Floss	4 boxes
Gauze	1 pack
Paper towel	5 rolls
Bibs	30
Dappen dish	40
Articulating paper	1 pack
Facemask	1 box
Gloves (XS, S, M)	1 box (XS), 2 boxes (S)
Protective glasses	4
Mouth prop.	4
OHI model	4 sets
Rubbish bags (small)	10
Cons kit	1

7. Dental chair and stationary	
Name	Quantity
Fibre optic torch	1
Portable light	2
Dental chair	2
Suction unit	1
Autoclave	1
ART kit	8
Pen	4
Pencil	4
Eraser	1
Adhesive tape	1
Plastic wrap	1
Ketac Molar	power x 2 ; liquid x 3
Suction tube	20